STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING 00 B. WING	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN47130

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W0000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: August 17, 18, 19, 22 and 26, 2011 Facility Number: 000956 Provider Number: 15G442 Aim Number: 100244760 Surveyor: Jo Anna Scott, Medical Surveyor III These deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/12/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 8 clients living in the home (client #8), the governing body failed to exercise operating direction over the facility to ensure the client's personal funds were not	W0104	**Corrective Action: (Specific)** The Program Coordinator and Accounts Payable will be retrained that a client's personal fund will not be used for professional services, such as a root canal. Client #8 will be	09/27/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	used to provide a root canal. Findings include: The record review of finances was conducted on 8/18/11 at 8:30 AM. The Resident Fund Management Service (RFMS) account for client #8 indicated a $250.00 deduction was made on 7/28/11. The description for the deduction indicated the deduction was for a root canal. Interview with staff #1, Home Manager/QMRP, on 8/18/11 at 8:45 AM indicated Medicare wouldn't pay for the root canal and since she had some money they used her personal funds. Interview with staff #10, Accounts payable, on 8/22/11 at 2:30 PM indicated the money was used from the clients personal account and they would enter a liability reduction request. Staff #10 indicated if and when they got the reduction, they would reimburse the client. Staff #10, indicated she did not know how long it would take for the reimbursement to be made to the client. 1.1-3-1(a)		reimbursed the $250.00 for her root canal. **How others will be identified: (Systemic)** The Program Coordinator at each home will ensure that no personal funds will be used to pay for professional services, such as a root canal. **Measures to be put in place:** The Program Coordinator and Accounts Payable will be retrained that a client's personal fund will not be used for professional services, such as a root canal. Client #8 will be reimbursed the $250.00 for her root canal. **Monitoring of Corrective Action:** Client finance records are reviewed monthly by the Accounts Payable Department. The Director of Finance will monitor and ensure that no client personal funds are being used for professional services, such as a root canal.	

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W0125	The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on record review and interview for 2 of 8 clients living in the home (clients #2 and #7), the facility failed to ensure the Health Care Representative (HCR) was a family member, clergy, or court ordered. Findings include: The 8/17/11 Residential Facility Surveyor Worksheet was reviewed 8/17/11 at 10:30 AM. The worksheet listed all the clients living in the home and indicated if they were represented by a guardian, HCR or advocate. Clients #2 and #7 were listed with the same HCR. Interview with staff #1, Home Manager/Qualified Mental Retardation Professional on 8/22/11 at 1:30 PM indicated clients #2 and #7 did not have any family that could act as their health care representative. Staff #1 indicated they did not attend church and didn't know any clergy. Staff #1 indicated the HCR they had was someone that wanted to help. Staff #1 indicated she was not aware the HCR had to be a family member, clergy or court appointed.	W0125	**Corrective Action: (Specific)** The Program Coordinator will be retrained that all Health Care Representatives must be a family member, clergy, or court appointed if members if the IDT agrees the client needs a Health Care Representative. The Program Coordinator held an IDT for Client #7 and determined that the client needs a Health Care Representative. The IDT for client #7 will also attempt to identify a Health Care Representative who is a family member, clergy, or an individual who agrees to follow the legal process to be appointed by the court. The IDT for Client #2 met and completed a Comprehensive Functional Assessment. The team determined that Client #2 is able to make informed decisions on her healthcare needs. The IDT will continue to review Client #2's competencies and if the status changes, the team will indentify a Health Care Representative for the individual. **How others will be identified: (Systemic)** At each client annual ISP meeting, comprehensive functional assessments will be reviewed so the IDT can make a decision if a Health Care Representative is needed for the individual. The team will seek a Health Care Representative who is	09/27/2011

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	1.1-3-2(a)		either a relative of the client or a member of the clergy. **Measures to be put in place:** The Program Coordinator will be retrained that all Health Care Representatives must be a family member, clergy, or court appointed if members if the IDT agrees the client needs a Health Care Representative. The Program Coordinator held an IDT for Client #7 and determined that the client needs a Health Care Representative. The IDT for client #7 will also attempt to identify a Health Care Representative who is a family member, clergy, or an individual who agrees to follow the legal process to be appointed by the court. The IDT for Client #2 met and completed a Comprehensive Functional Assessment. The team determined that Client #2 is able to make informed decisions on her healthcare needs. The IDT will continue to review Client #2's competencies and if the status changes, the team will indentify a Health Care Representative for the individual. **Monitoring of Corrective Action:** The Program Coordinator will assure that at all annual client ISP meetings, comprehensive functional assessments are reviewed to see if a Health Care Representative is needed for the individual. Contacts will be made for the Health Care Representative to be a relative or a member of the clergy.	

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W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 4 sampled clients (client #2), the facility failed to conduct an investigation of elopement from the home. Findings include: The BDDS (Bureau of Developmental Disability Services) incident reports were reviewed on 8/17/11 at 12:34 PM. The incident report for client #2 dated 8/1/11 indicated the following: "[Client #2] came to the med room to take her 8 PM med's. Told me she was done listen (sic) to the loud voices in the house and that she was going to her room. The next thing I know she walked out the front door. I had the other staff walk outside with her when [client #2] stated she was going walking. Staff went to look for [client #2] and while I was gone (another group home) called and said [client #2] was over there." The other group home is 2.3 miles from client #2's home. There was no investigation of the elopement conducted. The record review for client #2 was conducted on 8/18/11 at 3:39 PM. The Individual Support Plan (ISP) dated 3/19/11 indicated client #2 had a formal training goals of "Will display	W0154	**Corrective Action: (Specific)** The Director of Quality Assurance will retrain the Quality Assurance Staff that all elopements must be thoroughly investigated **How others will be identified: (Systemic)** The Program Coordinators for each home will report all alleged violations, including elopement, to Quality Assurance. The Quality Assurance Team will investigate all elopements. **Measures to be put in place:** The Director of Quality Assurance will retrain the Quality Assurance Staff that all elopements must be thoroughly investigated **Monitoring of Corrective Action:** The Director of Quality Assurance will report all violations, including elopement, immediately to the Executive Director for the Executive Director to review for appropriate action to be taken. The Executive Director will assure investigations are completed as required.	09/27/2011

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	community safety skills with verbal assistance for 70% of opportunities" and "Will use pedestrian safety skills when walking in community daily with 2 verbal prompts 65% of opportunities. The Behavior Management Plan dated 3/19/11 indicated client #2 had Elopement -"Anytime [client #2] leaves the group home property (or workshop property) without staff supervision." included as one of her targeted behaviors. Interview with staff #1, Home Manager/Qualified Mental Retardation Professional, on 8/22/11 at 1:30 PM indicated client #2 had eloped in the past. Staff #1 indicated she did have community access to walk to the park that was across the street. Staff #1 indicated client #2 had not told the staff she was walking to the other group home that was a number of blocks away. Interview with staff #5, Quality Assurance (QA) on 8/26/11 at 1:30 PM indicated they did not do an investigation because client #2 has community access to walk to the park. 1.1-3-2(a)			

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W0314	Drugs used for control of inappropriate behavior must be monitored closely in conjunction with the physician and the drug regimen review requirement at §483.460(j). Based on record review and interview for 1 of 4 sampled clients (client #4), the facility failed to conduct quarterly pharmacy reviews of medication used to conduct inappropriate behaviors. Findings include: The record review for client #4 was conducted on 8/18/11 at 11:42 AM. The Behavior Support Plan (BSP) dated 3/11/11 indicated client #4 received the following medications for behavior: Clonazepam for psychosis, Loxapine for schizophrenia, Gabapentin for schizophrenia and Zyprexa for schizophrenia. The records indicated client #4 had a follow-up at the psychiatrist on 9/1/10, 1/3/11 and 5/2/11 to review the medications. There was no indication the medication had been reviewed at any other times. Interview with staff #1, Home Manager/Qualified Mental Retardation Professional, on 8/22/11 at 1:30 PM indicated the doctor made the appointments and she didn't know why he did client #4's appointments at four month intervals.	W0314	**Corrective Action: (Specific)** The PC will be in-serviced on ensuring that all consumers receiving psychotropic medications are seen by the psychiatrist at least every three months. All consumers receiving psychotropic medications will be seen by the psychiatrist at least every three months. **How others will be identified: (Systemic)** The Program Director will complete random observations of the medical record to ensure that all consumers receiving psychotropic medications are seen by a psychiatrist at least every three months. **Measures to be put in place:** The PC will be in-serviced on ensuring that all consumers receiving psychotropic medications are seen by the psychiatrist at least every three months. All consumers receiving psychotropic medications will be seen by the psychiatrist at least every three months. **Monitoring of Corrective Action:** The Program Director will complete random observations of the medical record to ensure that all consumers receiving psychotropic medications are seen by a psychiatrist at least every three months.	09/27/2011

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	1.1-3-5(a)			